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ARIZONA STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL STATISTICS  
**CERTIFICATE OF DEATH**

STATE FILE NO.

REGISTRAR'S NO.

2902

41.

F DEATH 33 X RESIDENCE 5	1. PLACE OF DEATH A. COUNTY <u>Graham</u>		2. USUAL RESIDENCE A. STATE <u>Ariz</u> B. COUNTY <u>Graham</u>	
	B. CITY (IF OUTSIDE CORPORATE LIMITS, WRITE RURAL) <u>Safford</u>		C. CITY (IF OUTSIDE CORPORATE LIMITS, WRITE RURAL) <u>Safford, Ariz</u>	
	D. FULL NAME OF HOSPITAL OR INSTITUTION		D. STREET ADDRESS	
2 1 3 ONAL TA 170 4 649	3. NAME OF DECEASED A. (FIRST) <u>POLLY</u> B. (MIDDLE) <u>ELIZA</u> C. (LAST) <u>BROWN</u>		4. SEX <u>FM.</u> 5. COLOR OR RACE <u>W.</u>	
	6. MARried <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7. DATE OF BIRTH MONTH <u>Nov</u> DAY <u>11</u> YEAR <u>1870</u>	
	8. AGE YEARS <u>7</u> MONTHS <u>9</u> DAYS <u>9</u>		9A. USUAL OCCUPATION (GIVE KIND OF WORK DURING MOST OF LIFE, EVEN IF RETIRED)	
USE 331X IF ATH A 18)	9B. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Utah</u>	
	11. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		12. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, WAR OR DATES OF SERVICE)	
	13. SOCIAL SECURITY NO.		14A. FATHER'S NAME <u>David Henry Wallman</u>	
TIONS, OPSY TH TO RNAL ENCE	14B. BIRTHPLACE (STATE OR COUNTRY) <u>Utah</u>		15A. MOTHER'S MAIDEN NAME <u>Clara Cornelia Wall</u>	
	16. INFORMANT'S SIGNATURE <u>Bara B. Lang</u>		17. DATE OF DEATH <u>June 20-49</u>	
	18. CAUSE OF DEATH ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), (c). *THIS DOES NOT MEAN THE MODE OF DYING, SUCH AS HEART FAILURE, ASTHENIA, ETC. IT MEANS THE DISEASE, INJURY, OR COMPLICATION WHICH CAUSED DEATH. PLACE DISEASE CONTRACTIONS.		I. DISEASE OR CONDITIONS DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES MORBID CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (a) STATING THE UNDERLYING CAUSE LAST. DUE TO (b) <u>Supperteriosis</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATING TO THE DISEASE OR CONDITION CAUSING DEATH.	
CAL ONER'S CATION	19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21A. ACCIDENT SUICIDE HOMICIDE (SPECIFY)	
	21B. PLACE OF INJURY (E. G., IN OR ABOUT HOME, FARM, FACTORY, STREET, OFFICE BLDG., ETC.)		21C. (CITY OR TOWN) (COUNTY) (STATE)	
RAL 25 CTOR ID TRAR	21D. TIME (MONTH) (DAY) (YEAR) (HOUR) (MIN) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
	21F. HOW DID INJURY OCCUR?		22. I HEREBY CERTIFY THAT I ATTENDED THE DECEASED FROM 5/16/49 TO June 20, 1949, THAT I LAST SAW THE DECEASED ALIVE ON June 19, 1949 AND THAT DEATH OCCURRED AT 11:00 P.M. FROM THE CAUSES AND ON THE DATE STATED ABOVE.	
	23A. SIGNATURE <u>M. H. Safford</u>		23B. ADDRESS <u>Safford, Ariz</u>	
24A. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> REMOVAL <input type="checkbox"/>		24B. DATE <u>June 26</u>		
24C. NAME OF CEMETERY OR CREMATORY <u>Thatcher Cemetery</u>		24D. LOCATION (CITY, TOWN, OR COUNTY) (STATE) <u>Thatcher Ariz</u>		
25A. DATE REC'D BY LOCAL REG <u>July 9/1949</u>		25B. REGISTRAR'S SIGNATURE <u>M. G. Rawson</u>		
26. FUNERAL DIRECTOR'S SIGNATURE <u>Safford</u>				